Vermont Department of Corrections (DOC)
Authorization to Disclose Protected Health Information

Incomplete information: An incomplete form will result in a defective authorization. The DOC will not disclose protected health information with a defective authorization. Please make sure you fill in the **entire** form.

I, _____ Social Security #: _____-_____-_____
(*name of inmate*) Date of Birth: _____

authorize the Vermont Department of Corrections **to disclose to and receive protected health information from** the following:

_____

_____
(*name & address of person/agency to receive the disclosure*)

Type of Health Information

(Circle **RELEASE** or **DON'T RELEASE** for each type of information **(even if the entire record is requested)** so only the appropriate information is released):

Entire Medical Record	Release	Don't Release
Diagnosis / Presenting Problem	Release	Don't Release
Assessment Summaries / Evaluations	Release	Don't Release
Treatment Recommendations	Release	Don't Release
Treatment Plan / Support Agreement	Release	Don't Release
Progress Report on Treatment / Support	Release	Don't Release
Discharge Summary / Plan	Release	Don't Release
Medication Prescribed	Release	Don't Release
Test Results (specify): _____	Release	Don't Release
Mental Health Records/Psychotherapy Notes	Release	Don't Release
HIV/AIDS Diagnosis or Treatment Information	Release	Don't Release
Drug and Alcohol Information	Release	Don't Release

Other (be specific): _____
_____
_____

The Health Information to be released was created in the **time period:**

from _____ to _____;
Beginning date Ending date

or was created for: _____
E.g., treatment of particular condition/injury or other specific health issue

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The purpose of this disclosure is:

_____

_____

(If you don't want to specify a particular purpose, write "At the request of the individual" in this section.)

Means of disclosure (*check all that apply*):
☐ Written ☐ Oral ☐ Electronic ☐ Other: _____

I have read and understand the following:

- The reason(s) I am being asked to release information.
- I do not have to consent to the release of this information.
- Signing this authorization is voluntary. If I choose not to sign, my medical treatment will not be affected.
- If I am authorizing DOC to share information about **HIV-related**, or **alcohol or drug treatment**, the recipient may not share my information with others unless permitted to do so under state or federal law.
- Other types of health information used and disclosed in this authorization may be subject to re-disclosure and no longer protected under state or federal law.
- I will be provided with a copy of this form.
- I may revoke this authorization at any time except to the extent the DOC has already acted in reliance on it. To revoke this authorization, I must sign the revocation section of this form and submit it to the DOC.

Date or event upon which this authorization will expire: _____. I understand that if I do not specify a date or event, then this authorization will expire one year from the date it was signed below.

Individual's Signature: _____ **Date:** _____

REVOCATION

I hereby revoke this authorization on _____ (date) at _____ (time). Do not release any further information under this authorization.

Signature: _____

Send the completed authorization to:

Vermont Department of Corrections
Attn: Kimberly Gorton
NOB 2 South, 280 State Drive.
Waterbury, VT 05671-2000
Phone: 802-241-0025
Fax: 802-241-0020